Occupational Therapy
Appendices

Page #

Appendix 1
Sample Completed HCFA 1500 Claim Form
(Occupational Therapy)

APPROVED OMB-0938-0008

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID [T] (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M [ ] F [x]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I. M. Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 435.9 — 3. _____

2. 437.0 — 4. _____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 98	02 08 98	7	1	97150	OT	1	XXX XX	8.0				12345600
2 02 23 98		7	1	97110	OT	2	XXX XX	2.0				12345600
3 02 01 98		7	1	Q0109	OT	1	XXX XX	1.0				12345600
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ] — 26. PATIENT'S ACCOUNT NO. — 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ] — 28. TOTAL CHARGE $ XXX XX — 29. AMOUNT PAID $ XX XX — 30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized — MM/DD/YY

SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

I.M. Nursing Home
506 Willow
Anytown, WI 55555

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 86754321

PIN# — GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — ***PLEASE PRINT OR TYPE*** — FORM HCFA 1500 (12 90) FORM OWCP-1500 FORM RRB-1500

Appendix 1a
Sample Completed HCFA 1500 Claim Form
(Rehabilitation Agency)

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
(Medicare #) M (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY / SEX: MM DD YY M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY / SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 435.9
2. 437.0
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 98	02 08 98	7	9	97112	OT	1	XXXX	8.0				
2 02 23 98		7	9	97770	OT	2	XXXX	2.0				
3 02 01 98		7	9	Q0109	OT	1	XXXX	1.0				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XX.XX

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Provider MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
I.M. Nursing Home
506 Willow
Anytown, WI 55555

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555 87654300
PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA 1500 (12 90) FORM OWCP-1500 FORM RRB-1500

Appendix 1b
National HCFA 1500 Claim Form Completion Instructions for Occupational Therapy Services and Rehabilitation Agencies

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers should always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter the claim sort indicator:

"T" - Occupational Therapy Services.
"M" - Rehabilitation Agency.

Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number
Enter the recipient's 10-digit identification number from the current identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (i.e., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
You must bill health insurance (commercial insurance coverage) prior to billing Wisconsin Medicaid unless the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook. Leave this element blank when:

1. The provider has not billed health insurance because the "Other Coverage" of the recipient's Medicaid identification card is blank.

2. The service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook.

3. The recipient's Medicaid identification card indicates "DEN" only.

4. You must indicate one of the following codes in the first box of element 9 when "Other Coverage" of the recipient's Medicaid identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A, the all-provider handbook. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.):

Code	*Description*
OI-P	Use the OI-P disclaimer code when the health insurance pays in part. The claim indicates the amount paid by the health insurance company to the provider or the insured.
OI-D	Use the OI-D disclaimer code only when these three criteria are met: ◆ The "Other Coverage" field on the recipient's ID card shows HPP, BLU, WPS, CHA, DEN, or OTH. ◆ The service requires billing health insurance before Wisconsin Medicaid. ◆ You have billed the health insurance and received a denial from the insurance company.
OI-Y	Use the OI-Y disclaimer code when the card indicates other coverage but it was not billed for reasons including: ◆ The provider knows the service in question is noncovered by the insurer. ◆ Insurance failed to respond to a follow-up claim. ◆ When "Other Coverage" of the recipient's Medicaid identification card indicates "HMO" or "HMP," one of the following disclaimer codes must be indicated if applicable:

Code	*Description*
OI-P	Use the OI-P disclaimer code when the health insurance pays in part. The amount paid is indicated on the claim.
OI-H	Use the OI-H disclaimer code only when these two criteria are met: ◆ The "Other Coverage" field on the recipient's ID card is HMO or HMP. ◆ The HMO or HMP does not cover the service or the billed amount does not exceed the coinsurance or deductible amount.

Note: You may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Wisconsin Medicaid does not reimburse services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group, or FECA Number

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed before billing Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not pay, indicate one of the following Medicare disclaimer codes. The description is not required.

Code	*Description*

M-1 Medicare benefits exhausted. This code applies when Medicare has denied the claim because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.

Use M-1 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A but is denied due to benefits being exhausted.

For Medicare Part B (all three criteria must be met):

- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B but is denied due to benefits being exhausted.

M-5 Provider not Medicare certified. This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified, or cannot be Medicare Part A or Part B certified.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is not certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A.

For Medicare Part B (all three criteria must be met):

- The provider is not certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B.

M-6 Recipient not Medicare eligible. This code applies when Medicare denied the claim because there is no record of the recipient's eligibility. Use M-6 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is certified for Medicare Part A.
- The service is covered by Medicare Part A.
- The recipient is not eligible for Medicare Part A.

For Medicare Part B (all three criteria must be met):

- The provider is certified for Medicare Part B.

- The service is covered by Medicare Part B.
- The recipient is not eligible for Medicare Part B.

M-7 Medicare disallowed or denied payment. This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A but is denied by Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B but is denied by Medicare.

M-8 Noncovered Medicare service. This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of services that are not covered under Medicare is in Appendix 16 of Part A, the all-provider handbook.

Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is not covered under Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is not covered under Medicare Part B.

Leave the element blank if Medicare is not billed because the recipient's Medicaid identification card indicated no Medicare coverage.

Leave the element blank if Medicare allows an amount on the recipient's claim. Attach the Explanation of Medicare Benefits (EOMB) to the claim. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for more information about the submission of claims for dual-entitlees.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source
Enter the referring or prescribing physician's name.

Element 17a - I.D. Number of Referring Physician
Enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the Medicaid provider number or license number of the referring provider. Refer to Appendix 3 of Part A, the all- provider handbook, for the UPIN directory address.

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use
If an unlisted procedure code is billed, describe the procedure. If element 19 does not provide enough space for the procedure description, or if multiple unlisted procedure codes are being billed, attach documentation to the claim describing the procedure(s). In this instance, indicate "See Attachment" in element 19.

Element 20 - Outside Lab (not required)

Element 21 - Diagnosis or Nature of Illness or Injury
Enter *The International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization
Enter the seven-digit prior authorization number from the approved prior authorization request form. Bill services authorized under multiple prior authorizations on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for each procedure is identical. (Enter the total charge *per detail line* in element 24f.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

Element 24b - Place of Service
Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 3 of this handbook for a list of allowable place of service codes for occupational therapy services.

Element 24c - Type of Service Code
Enter the appropriate single-digit type of service code. Refer to Appendix 3 of this handbook for a list of allowable type of service codes for occupational therapy services.

Element 24d - Procedures, Services, or Supplies
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers. Refer to Appendix 4 of this handbook for a list of allowable procedure codes for occupational therapy services.

Element 24e - Diagnosis Code
When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24d) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges
Enter the total charge for each line.

Element 24g - Days or Units
Enter the total number of services billed for each line. Occupational therapy services must be billed following the *Conversion of Therapy Treatment Time Guidelines* in Appendix 5 of this handbook.

Element 24h - EPSDT/Family Planning
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG
Enter an "E" for *each* procedure performed as an emergency regardless of the place of service. If the service is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for Local Use
Enter the eight-digit provider number of the performing provider *for each procedure* if it is different than the billing provider number indicated in element 33.

Note: Rehabilitation agencies do not indicate a performing provider number.

When applicable, enter the word "spenddown" and under it, enter the spenddown amount on the last detail line of element 24k directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.
Optional - The provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
Not required. Provider automatically accepts assignment through Medicaid certification.

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance Due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24k and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

Note: This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code, and Telephone
Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number.

Appendix 2
Electronic Media Claims Screen

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 010193
EDS - WISCONSIN MEDICAID

BP NBR 33 L NAME 2 F NAME 2 MID 1A
PCN 26 OI 9 TPL 10 MSC 11 PA NBR 23
RP NBR 17 FP NBR 32 OP NBR
DIAG 1 21.1 2 21.2 3 21.3 4 21.4 5

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	24A	A	B	D	D	D	K	E	F	G	C	I	H
2													
3													
4													
5													
6													
7													
8													
9													
10													

TOT BILL 28 OI PAID 29 PAT PAID 24K NET BILL 30

Doc #1 Page #1 Field #6 Form: MEDVENDR 01-01-1993 10:17:35

Benefits of Electronic Claim Submission

One of the greatest benefits of electronic claim submission is that less information from providers is required for processing. Less information means less room for error. The data elements *not* required on electronic claims include the following:

- ✓ Claim sort indicator.
- ✓ Patient's address.
- ✓ Patient's date of birth.
- ✓ Signature of provider.
- ✓ Patient's sex.
- ✓ Provider's name and address.

Other benefits of billing electronically include the following:

- ✓ Free software.
- ✓ Improved cash flow.
- ✓ Online edits.
- ✓ Lower detail denial rate.
- ✓ Flexible submission methods.
- ✓ Claim entry controlled by provider.

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at the address located in Section IV of this handbook.

Appendix 3
Wisconsin Medicaid
Place of Service and Type of Service Codes
for Occupational Therapy Services

Billing on the HCFA 1500 Form

Wisconsin Medicaid Allowable Place of Service (POS) Codes	
POS Code	**Description**
0	Other
3	Office (including services off the licensed hospital location)
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Wisconsin Medicaid Allowable Type of Service (TOS) Codes	
TOS Code	**Description**
1	Medical (Occupational Therapy Services)
9	Rehabilitation Agency Services

Appendix 4
Wisconsin Medicaid Allowable Current Procedural Terminology and HCPCS Procedure Codes and Copayments for Occupational Therapy Services

Allowable Types and Places of Service for Specific Service Providers	
Rehabilitation Agencies [Type of Service (TOS) = 9]	Independent Therapists, Therapy Groups, and Therapy Clinics [Type of Service (TOS) = 1]
Allowable Places of Service = 0, 3, 4, 7, 8	Allowable Places of Service = 0, 3, 4, 7, 8

Modalities

CPT Procedure Code	Description	Copayment for CPT/ HCPCS Code	Daily Service Limit	Procedure Allowable for Therapy Assistants
90901	Biofeedback training by any modality (15 minutes)	$2.00	Not Applicable	Allowed
97010	Application of a modality to one or more areas; hot or cold packs (15 minutes)	$1.00	1 per day	Allowed
97018	Application of a modality to one or more areas; paraffin bath (15 minutes)	$1.00	1 per day	Allowed
97034	Application of a modality to one or more areas; contrast baths (15 minutes)	$0.50	Not Applicable	Allowed

Therapeutic Procedures

CPT Procedure Code	Description	Copayment for CPT/ HCPCS Code	Daily Service Limit	Procedure Allowable for Therapy Assistants
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility	$1	Not applicable	Allowed
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	$1	Not Applicable	Allowed
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	$1	Not Applicable	Allowed
97139	Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)	$1	Not Applicable	Allowed
97150	Therapeutic procedure(s), group (2 or more individuals) (each 15 minutes)	$0.50	Not Applicable	Allowed
97250	Myofascial release/soft tissue mobilization, one or more regions (15 minutes)	$1	Not applicable	Not Allowed
97265	Joint mobilization, one or more areas (peripheral or spinal) (15 minutes)	$2	1 per day	Not Allowed
97520	Prosthetic training; upper and/or lower extremities, each 15 minutes	$1	Not Applicable	Allowed
97530	Therapeutic activities, direct (one-on-one) patient contract by the provider (use of dynamic activities to improve functional performance), each 15 minutes	$1	Not Applicable	Allowed
97535	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions of adaptive equipment) direct one-on-one contact by the provider, each 15 minutes	$1	Not Applicable	Allowed
97542	Wheelchair management, propulsion training, each 15 minutes	$1	Not Applicable	Allowed

Other Procedures

CPT Procedure Code	Description	Copayment for CPT/ HCPCS Code	Daily Service Limit	Procedure Allowable for Therapy Assistants
97770	Development of cognitive skills to improve attention, memory, problem solving, including compensatory training and/or sensory integrative activites, direct (one-on-one) patient contact by the provider, each 15 minutes	$1	Not Applicable	Allowed

Comprehensive Evaluation

CPT Procedure Code	Description	Copayment for CPT/ HCPCS Code	Daily Service Limit	Procedure Allowable for Therapy Assistants
97003	Occupational therapy evaluation (15 minutes)	$1	Not Applicable	Not Allowed
97004	Occupational therapy re-evaluation (15 minutes)	$0.50	2 per day	Not Allowed

Appendix 5
Conversion of Therapy Treatment Time to Wisconsin Medicaid Treatment Units for Billing Purposes

The following charts illustrate the calculation of units of time for billing face-to-face occupational therapy services.

CONVERSION TABLE 1
Treatment Time to Treatment Units for Procedure Codes Referencing "15 Minutes of" in the Procedure Code Description

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
7.5	0.5
15.0	1.0
22.5	1.5
30.0	2.0
37.5	2.5
45.0	3.0

CONVERSION TABLE 2
Treatment Time to Treatment Units for Procedure Codes Referencing "30 Minutes of" in the Procedure Code Description

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
15.0	0.5
30.0	1.0
45.0	1.5
60.0	2.0
75.0	2.5
90.0	3.0

Appendix 6
List of Evaluations, Tests, and Measures

An evaluation consists of one or more tests or measures used in assessing a recipient's needs. A written report of the evaluation results must accompany the test chart/form in the recipient's medical record.

Evaluations are counted toward the 35-day spell of illness prior authorization threshold.

The following list includes tests and measures which may be used in an evaluation:

1. Motor skills include the following:
   - Range-of-motion.
   - Gross muscle test.
   - Manual muscle test.
   - Coordination evaluation.
   - Nine-hole peg test.
   - Purdue pegboard test.
   - Strength evaluation.
   - Head-trunk balance evaluation.
   - Standing balance-endurance.
   - Sitting balance-endurance.
   - Prosthetic balance.
   - Hemiplegic evaluation.
   - Arthritis evaluation.
   - Hand evaluation-strength and range of motion.
2. Sensory integrative skills include the following:
   - Beery test of visual motor integration.
   - Southern California kinesthesia and tactile perception test.
   - Milloni-Comparetti developmental scale.
   - Gessell developmental scale.
   - Southern California perceptual motor test battery.
   - Marianne Frostig developmental test of visual perception.
   - Reflex testing.
   - Ayres space test.
   - Sensory evaluation.
   - Denver developmental test.
   - Perceptual motor evaluation.
   - Visual field evaluation.
3. Cognitive skills include the following:
   - Reality orientation assessment.
   - Level of cognition evaluation.
4. Activities of daily living skills include the following:
   - Bennet hand tool evaluation.
   - Crawford small parts dexterity test.
   - Avocational interest and skill battery.
   - Minnesota rate of manipulation.
   - ADL evaluation-men and women.
5. Social interpersonal skills-evaluation of response in group.
6. Psychological intrapersonal skills include the following:
   - Subjective assessment of current emotional status.
   - Azima diagnostic battery.
   - Goodenough draw-a-man test.
7. Therapeutic adaptations.
8. Environmental planning, environmental evaluation.

Appendix 7
List of Procedures

Covered occupational therapy treatment procedures are the services listed on this page. If they are medically necessary, their services include, but are not limited to, the following:

√ Motor skills.

√ Sensory integrative skills.

√ Cognitive skills.

√ Activities of daily living skills.

√ Social interpersonal skills.

√ Psychological intrapersonal skills.

√ Preventive skills.

√ Therapeutic adaptations.

√ Environmental planning.

A complete description of covered occupational therapy services is included in *Wisconsin Medicaid Provider Updates*. These *Updates* list billable services by procedure code. Refer to Appendix 4 of this handbook for a current list of procedure codes.

Appendix 8
Sample Prior Authorization Request Form for Occupational Therapy Services

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 0750456

1 PROCESSING TYPE: 111

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890	4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.	
5 DATE OF BIRTH: MM/DD/YY (Child)	6 SEX: M ☐ F ☒
8 BILLING PROVIDER TELEPHONE NUMBER: (xxx) xxx-xxxx	
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M Billing 1 W.Williams Anytown, WI 55555	9 BILLING PROVIDER NO. 87654300
	10 DX: PRIMARY: 343.9 C.P.
	11 DX: SECONDARY
	12 START DATE OF SOI: / 13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
Q0110	OT	3	1	Re-evaluation	01	xxxx
97535	OT	3	1	Activities of daily living (each 15 min.)	40	xxxx
97112	OT	3	1	Kinesthetic sense, balance, proprioception	40	xxxx
				(each 15 min.)		
97770	OT	3	1	Sensory integrative (each 15 min.)	40	xxxx
*Each session will include a combination of codes totalling 45 minutes.						
					TOTAL CHARGE	21 xxxx

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE) 24 I.M. Provider, O.T.R. Please begin P.A. XX/XX/XX (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

☐ MODIFIED – REASON:

☐ DENIED – REASON:

☐ RETURN – REASON:

DATE _____ CONSULTANT/ANALYST SIGNATURE _____

482-120

Appendix 8a
Prior Authorization Request Form Completion Instructions
(Occupational Therapy)

* See Appendix 10a of this handbook for Spell of Illness PA/RF instructions.

Element 1 - Processing Type
Enter processing type 111, occupational therapy.

Element 2 - Recipient's Wisconsin Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, first name, and middle initial from the recipient's current identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *No other information should be entered in this element since it also serves as a return mailing label.*

Element 8 - Billing Provider's Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Provider's Wisconsin Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis *code and description most* relevant to the service/procedure requested.

Element 11 - Recipient's Secondary Diagnosis
When there is a secondary diagnosis, enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness
Do not complete this element *unless* requesting a therapy (PT, OT, speech) spell of illness. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 13 - First Date of Treatment
Do not complete this element *unless* requesting a therapy (PT,OT, speech) spell of illness. Enter the date of the first

treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 14 - Procedure Code(s)

Enter the appropriate HCFA Common Procedure Coding System (HCPCS) procedure code as described in the plan of care in this element.

Element 15 - Modifier

Enter the "OT" modifier appropriate for each procedure code.

Element 16 - Place of Service

Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
3	Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

Element 17 - Type of Service

Enter the appropriate type of service code for each service/procedure/item requested. *Do not complete* this element if requesting a therapy (occupational therapy) spell of illness.

Numeric	Description
1	Medical
9	RehabilitationAgency

Element 18 - Description of Service

Enter a written description corresponding to the appropriate HCPCS procedure code for each service/procedure requested.

Element 19 - Quantity of Service Requested

Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure requested.

Element 20 - Charges

Enter your usual and customary charge for each service/procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element.

Note: The charges indicated on the *request form* should reflect the provider's usual and customary charge for the procedure requested. Providers are paid for authorized services according to the Department of Health and Family Services's (DHFS) *Terms of Provider Reimbursement.*

Element 21 - Total Charge

Enter the anticipated total charge for this request.

Element 22 - Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment is not to be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program.

Element 23 - Date

Enter the month, day, and year (in MM/DD/YY formate) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element. Providers must enter the requested start date after the requesting provider's signature.

Do not enter any information below the signature of the requesting provider. This space is used by Medicaid consultant(s) and analyst(s).

Appendix 9
Sample Prior Authorization Therapy Attachment
(Occupational Therapy)

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT
(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
Recipient	Ima	A	1234567890	3

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. Performing, P.T.	12345678	(XXX) XXX XXXX

⑨ I.M. Referring/Prescribing
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. Requesting: ☒ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested: 45 minutes
Total Sessions per week requested: 2x per week
Total number of weeks requested: 20 wks.

C. Provide a description of the recipient's diagnosis and problems including date of onset.

Female has a diagnosis of cerebral palsy. She also has a seizure disorder and exhibits delays in all areas of development.
Onset birth.

D. Brief Pertinent History:

Female is a twin, born at 24.5 wks. gestation. She was hospitalized for 4 months following birth. She was ventilator-dependent for 8 weeks. Recipient resides at home with twin brother, parents, and 2 older siblings. Seizures are currently controlled with _____ (Medication). Vision and hearing tested in _____ (MM/YY) and judged to be WNL. She wears bilateral night splints and bilateralAFOs. Family has mobility base with positioning and bathing adaptations.

	Location	Date	Problem Treated
E. Therapy History:			
PT	XYZ	1/2/XX to 1/11/XX	LE ROM Muscle tone Trunk central Positioning
OT	XYZ	1/2/XX to 1/11/XX	UE ROM Splinting ADL NDT
SP	N/A		

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation)

Initial evaluation completed MM/DD/YY on PA #1234567

See attached evaluation completed _____(MM/DD/YY).

M-Team evaluation and IEP dated _____(MM/DD/YY) (most current) are attached.

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

MM/DD/YY	MM/DD/YY
1. *Shoulder flexion* Was ____*.	Now is____*.
2. *Dressing* Was able to lift and push through sleeve until wrist in 3 of 3 trials.	Now can push through sleeve to mid-forearm in 1 of 3 attempts.
3. *Sidesit* Right weight bear on forearm--Required physical assist to assume position and tolerate it for 15 seconds.	Requires no assistance to assume position and tolerates it for 45 seconds.
4. *Tactile defensiveness* Previously immediately withdrew both hands from rice, sand, pudding, and various fabrics when physically placed on texture.	Now tolerates left hand placement on terry cloth and pudding for 15 seconds in 4 of 4 trials. Right hand tolerates physical placement on felt for 10 seconds in 6 of 10 trials.
5. *Transfer of cube - midline* Was able to hold 1 inch cube in one hand. No observation of hands at midline.	Now hold 1 inch at midline, but does not release to transfer to other hand

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

1. Long-term goal (LTG): Maintain/increase both shoulder ROM to encourage active participation in UE dressing in 6 months.
   Short-term objective (STO): Increase RUE shoulder flexion 120° so that the child can lift arms and push RUE through shirt sleeve in 2 of 3 attempts when shirt is presented (97535).

2. LTG: Demonstrate trunk elongation to maintain upright sitting for self-feeding in 8 months.
   STO: Sidesit R for trunk elongation/ R weight bear on forearm without assistance, to maintain for 1 minute (97112).

3. LTG: Decrease tactile sensitivity to allow participation in hand washing without aversive reaction within 1 year.
   STO: Will seek and tolerate tactilely challenging materials with both hands for a duration of 30 seconds in 2 of 4 trials (97770).

4. LTG: Increase bilateral hand use for functional grasp in finger feeding within 6 months.
   STO: Will improve function thumb/finger opposition to be able to transfer 1" cube from one hand to the other 2 out of 5 trials (97112).

I. Rehabilitation Potential:

Given gains made in tolerance to handling and successful reduction in muscle tone, continued progress toward functional self-help skills is demonstrated. Recommend continuing treatment in addition to school therapy which currently provides 30-minute consult only. Therapist has contacted on ____ (MM/DD/YY) and does so bimonthly. A notebook is exchanged. Carryover plan for family is also attached.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J.

I. M. Referring	*I. M. Performing, O.T.R.*
Signature of Prescribing Physician (A copy of the Physician's order sheet is acceptable)	Signature of Therapist Providing Treatment
MM/DD/YY	MM/DD/YY
Date	Date

Appendix 9a
Prior Authorization Therapy Attachment Completion Instructions
(Occupational Therapy)

Do not use this attachment to request a spell of illness; use the Prior Authorization Spell of Illness Attachment (PA/SOIA).

Timely determination of prior authorization is significantly increased by submitting thorough documentation when requesting prior authorization to extend treatment beyond 35 treatment days for the same spell of illness. Carefully complete the Prior Authorization Therapy Attachment (PA/TA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to:

Attn: Prior Authorization, Suite 88
EDS
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/TA may be directed to the fiscal agent's Policy/Billing Correspondence Unit. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

Element 4 - Recipient's Wisconsin Medicaid Identification Number
Enter the recipient's ten-digit identification number from the recipient's current identification card.

Element 5 - Recipient's Numerical Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

Provider Information:

Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter the name of the supervising therapist.

Element 7 - Therapist's Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the telephone number of the supervising therapist.

Element 9 - Referring/Prescribing Physician's Name
Enter the name of the physician referring/prescribing evaluation/ treatment.

Use the remaining portion of this attachment to document the justification for the requested service.

1. Complete elements A through J.

2. Element E - Provide a brief past history based on available information.

   Element F - Provide the evaluation results (you may attach the therapy evaluation to comply with this requirement).

   Element I - Provide the recipient's perceived potential to meet therapy goals.

3. Read the 'Prior Authorization Statement' before signing and dating the attachment.

4. The attachment must be signed and dated by the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, the supervising therapist must sign the attachment.

   The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by the fiscal agent indicating the physician's signature is acceptable). If the required documentation is missing from the request form, the request is returned to the provider requesting the required information.

5. Refer to Section III- E of this handbook for additional attachments that may be required.

Appendix 10
Prior Authorization Request Form
Spell of Illness Sample (Occupational Therapy)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 115

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567892
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, ImA.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M ☐ F ☒
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX)XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. Provider, 1 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 10000000
10 DX: PRIMARY: 854T.B.I.
11 DX: SECONDARY: 814.0 (R) Wrist fx.
12 START DATE OF SOI: MM/DD/YY
13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
Q0109	0T	8	9	Evaluation	01	
97535	0T	8	9	Act of daily living (each 15 min.)	34	
97770	0T	8	9	Cognitive - memory (each 15 min.)	34	
97110	0T	8	9	Range of motion (each 15 minutes)	34	
97265	0T	8	9	Joint mob. periph. (initial 15 min.)	12	
97250	0T	8	9	Myofas. Rel/Soft tissue (each 15 min.)	34	
*Each session will include 30 min. ADL and combination of other procedures to *equal* one hour of treatment					TOTAL CHARGE	21

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)
24 *I.M. Provider* Begin SOI MM/DD/YY (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED
☐ MODIFIED — REASON:
☐ DENIED — REASON:
☐ RETURN — REASON:

DO NOT write in this space.
Reserved for Medicaid use.

DATE — CONSULTANT/ANALYST SIGNATURE

482-120

Appendix 10a
Prior Authorization Request Form for Spell of Illness
Completion Instructions (Occupational Therapy)

Element 1 - Processing Type
Enter processing type 115, occupational therapy (spell of illness only).

Element 2 - Recipient's Wisconsin Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, followed by first name and middle initial, from the recipient's current identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *No other information should be entered in this element since it also serves as a return mailing label.*

Element 8 - Billing Provider's Telephone Number
Enter the *billing provider's* telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Provider's Wisconsin Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate International Classification of Diseases, 9th Revision, Clinical Modification diagnosis *code and description most* relevant to the service/procedure requested.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness
Enter the date of onset for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 13 - First Date of Treatment
Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 14 - Procedure Code(s)
Enter the procedure code as described in the plan of care.

Element 15 - Modifier
Enter the "OT" modifier appropriate for each procedure code.

Element 16 - Place of Service
Enter the appropriate place of service code.

Numeric	Description
0	Other
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested. This includes therapy services and therapy spells of illness (occupational therapy).

Numeric	Description
1	Medical
9	Rehabilitation Agency

Element 18 - Description of Service
Enter the appropriate procedure code description.

Element 19 - Quantity of Service Requested
Enter the number of treatment days requested, per procedure code.

Element 20 - Charges (leave this element blank)

Element 21 - Total Charge (leave this element blank)

Element 22 - Billing Claim Payment Clarification Statement
Please read the "Billing Claim Payment Clarification Statement" printed on the request before dating and signing the prior authorization request form.

> "An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program."

Element 23 - Date
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

**Do not enter any information below the signature of the requesting provider -
This space is reserved for Medicaid consultant(s) and analyst(s).**

Appendix 11
Sample Prior Authorization Spell of Illness Attachment

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A	1234567890	55

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. Performing, OTR	87654321	(XXX) XXX -XXXX

(9) I. M. Referring
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. ☐ Physical Therapy SOI ☒ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems.
Indicate the functional regression which has occurred and the potential to reachieve the previous skill level.
Recipient was involved in M.V.A. MM/DD/YY with resultant T.B.I with coma and other multiple internal injuries and orthopedic complications. Acute hospitalization and follow-up rehabilitation on MM/DD/YY. Recipient was discharged home on MM/DD/YY. Upon discharge to home, recipient was able to ambulate without assistance, perform all ADLs with minimal cueing from memory book and relied on memory book to perform cognitive tasks. Family completed housekeeping tasks. Nine months later, regression in the ability to perform self care was noted, and was admitted to a nursing home for the purpose of regaining functional abilities.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.
SeeAttached

D. What is the anticipated end date of the spell of illness?
MM/DD/YY

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. *I. M. Prescribing* — Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — MM/DD/YY — Date

G. *I M Performing* — Signature of Therapist Providing Evaluation/Treatment — MM/DD/YY — Date

Appendix 11a
Prior Authorization Spell of Illness Attachment
Completion Instructions

Do not use this attachment to request prior authorization (PA) to extend treatment beyond 35 treatment days for the same spell of illness; use the Prior Authorization Therapy Attachment (PA/TA).

Timely determination of PA is significantly increased by submitting thorough documentation when requesting PA for a spell of illness. Carefully complete the Prior Authorization Spell of Illness Attachment (PA/SOIA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to:

Prior Authorization, Suite 88
EDS
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/SOIA may be directed to the fiscal agent's Policy/Billing Correspondence Unit. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

Element 4 - Recipient's Wisconsin Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 5 - Recipient's Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

Provider Information:

Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter his/her name and credentials, also enter the name of the supervising therapist.

Element 7 - Therapist's Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her provider number, also enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her telephone number and the telephone number of the supervising therapist.

Element 9 - Referring/Prescribing Physician's Name

Enter the name of the physician referring/prescribing evaluation/treatment.

Part A

Enter an "X" in the appropriate box to indicate a physical, occupational, or speech therapy spell of illness request.

Part B

Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential is to reachieve the previous skill.

Part C

Attach a copy of the recipient's Therapy Plan of Care, including a current dated evaluation, to the Spell of Illness attachment before submitting the spell of illness request.

Part D

Enter the anticipated end date of the spell of illness in the space provided.

Part E

Attach the physician's dated signature on either the Therapy Plan of Care or the copy of the physician's order sheet. Read the 'Prior Authorization Statement' before signing and dating the attachment.

Part F

The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the physician's order sheet is acceptable.)

Part G

The dated signature of the therapist providing evaluation/treatment must appear in the space provided.

Appendix 12
Spell of Illness Guide

The following table includes some examples to help providers determine when to submit a spell of illness form versus a prior authorization (PA) form.

Injury/Illness	Submit PA/Spell of Illness Forms?	Treatment Days	Submit PA/TA Form?
First time in treatment (femoral fracture)	no	30 days	n/a
Second time in treatment (mild CVA-ability to reachieve ADLS is possible)	yes	65 days	Submit the PA/RF and PA/TA forms to the fiscal agent within two weeks before spell of illness ends for additional 30 days
Third time in treatment (decubitus ulcer)	The diagnosis never qualifies for a spell of illness.	100 days	Submit PA/RF and PA/TA forms to the fiscal agent within two weeks of evaluation.
Fourth time in treatment (humeral fracture)	yes	26 days	n/a
Fifth time in treatment (severe CVA-ability to reachieve ADLS is questionable)	Does not qualify as spell of illness	14 days	Submit PA/RF and PA/TA forms to the fiscal agent within two weeks of evaluation.

Appendix 13
Helpful Hints for Working With Wisconsin Medicaid

The following tips are a compilation of information collected from providers participating in the Wisconsin Occupational Therapy Association (WOTA) Medicaid Committee and information presented at symposiums sponsored by the committee. The information has been edited and updated by the Bureau of Health Care Financing therapy consultants. These tips are meant as guidelines to improve your documentation and to assist you in completing Medicaid forms accurately and completely.

Prior Authorizations (PAs)

- If information regarding the recipient's previous therapy history is unavailable, submit a PA request.
- Fill out all forms completely and accurately. Each time a PA request is sent back to the provider for more information, there is a delay in services.
- A PA request should be sent to the fiscal agent at least two weeks, but no more than three weeks, before the expiration date of the existing prior authorization.
- Check the recipient's 10-digit identification number before mailing the request to the fiscal agent.
- Please list onset dates for all diagnoses. If specific dates are not available, enter an approximate date based on the best information available and explain the circumstances.
- Count weeks and sessions accurately to ensure authorizations for sufficient sessions. Count from the requested start date. Remember, the consultant cannot grant more than you request. Please indicate if the recipient has been put "on hold" until the PA is finalized.
- The initial request for PA can be backdated two weeks to the date the request is initially received by the fiscal agent. Continuous therapy may not be backdated. To request backdating, write "Please backdate to (*date)* because (*reason*)" on the prior authorization request form (PA/RF).
- In the event that your initial PA request is returned for clarification, provide written clarification and attach your response to the original PA/RF and return this PA/RF with all attachments to the fiscal agent. The original PA/RF was stamped with the internal control number (ICN) date when it was first received by the fiscal agent. The PA may be backdated to the ICN date only if you specifically request this.
- In cases when you have difficulty getting a doctor's signature on the initial plan of care which has caused your PA to be late, attach a memo of explanation which the fiscal agent may consider in dating your authorization.
- The codes at the bottom of the PA/RF near the consultant's signature are common messages regarding action or recommendations by the consultant which have been assigned a computer code.
- Remember to use black ink. This makes the photocopies easier to read.
- A plan of care must be formulated from a valid data base (evaluation). PAs are not approved if the evaluation results are not included.
- If there is an interruption in services and you have excess sessions to use, you may change frequency if appropriate for the recipient, as long as you don't exceed the number of sessions granted or the end date. Include an explanation of the circumstances on your next PA. An amendment cannot be granted in this case.

Hints (continued)

- You may change your treatment plan during a PA; however, be sure to include the dates and rationale on your next PA request.
- Please write legibly and ensure legibility of copies. If the consultant cannot read your documents, they may get sent back.
- Only use basic or common abbreviations.
- If your PA is returned "denied," you have the right to call the consultant to discuss the decision. If the consultant agrees to change the decision, submit a new PA request with the additional documentation required by consultant. Attach a copy of the denied PA.
- If the consultant stands by the denial, the recipient has the right to appeal through the fair hearing process.
- PAs returned to the provider for more information must be returned to the fiscal agent within a two-week period.
- If the reviewing consultant writes "D/C at end of PA" on the returned PA/RF, and you feel the recipient would benefit from further treatment, write another prior authorization clarifying medical reason for additional treatment.
- Make sure your goals are objective, measurable, and functional.
- Record all progress, no matter how small.
- Include function and safety issues when appropriate.
- Use standardized evaluations whenever possible. Attach the complete evaluation to the PA request. Summarized evaluations usually do not include the full information required by the reviewing consultant to determine medical necessity.
- Include norms with test scores.
- Include specific carryover recommendations for patient, facility, staff, and/or family. After six months, carryover must be demonstrated to grant continued treatment.
- Highlight pertinent data.
- Suggested formats:
  - List your data in columns - past and present.
  - Use areas, problems resolved, problems improved, problems unresolved, carryover.
- Maintenance is a covered treatment, as long as *skilled* therapy services are required.
- "Medical Necessity" is defined in HFS 101.03 (96m), Wis. Admin. Code.

Hints (continued)

Spells of Illness (SOIs)

- New diagnoses or exacerbations that result in a functional regression generally qualify as a spell of illness.
- Be sure to include a copy of the current evaluation, a comparison to prior abilities, and an estimate of the patient's ability to return to prior level of function.
- Remember, any health insurance, including Medicare-paid sessions (excluding inpatient hospital days) *count* toward the original 35 days of treatment for a spell of illness.
- You may submit a copy of the monthly signed doctor's orders in lieu of a signature on the Prior Authorization Therapy Attachment (PA/TA), as long as the order indicates what treatment the doctor is prescribing.

General Information

- BID treatment counts as one session, so long as it does not exceed 90 minutes per day.
- Daily treatment time should not exceed the limitation of 90 minutes, per treatment day. However, under extraordinary circumstances you may request more time. After you receive payment for the 90 minutes, submit an adjustment form with the specific reason for exceeding the 90 minute limitation documented on the adjustment form.
- Make sure treatment and documentation are in accordance with the Wisconsin Administrative Code laws and practice standards.
- Splinting treatment, including evaluation and associated expenses, is billed separately from other treatment sessions as durable medical equipment. Refer to the Durable Medical Equipment (DME) Index for correct procedure codes.

Appendix 14
Wisconsin Medicaid Declaration of Supervision and Authorization to Pay Agreement for Non-Billing Providers

The following providers are issued non-billing provider numbers (*cannot be used independently* to bill Wisconsin Medicaid), must be under professional supervision to be Medicaid-certified providers and *must* complete this form:

Alcohol and Other Drug Abuse Counselor (31/048)
Psychiatric Nurse (31/049)
Master's Level Psychotherapist (31/078)
Physical Therapy Assistant (34/077)
Occupational Therapy Assistant (35/114)
Speech Pathologist, BA Level (78/091)
Physician Assistant (88/079)

Return to: EDS, Attn: Provider Maintenance, 6406 Bridge Road, Madison, WI 53784-0006

To be completed by the applicant who is a Non-Billing Provider or Current Non-Billing Provider who has a Change in Work Address or Supervisor (always required):

Name and Credentials:_____ Phone:(_____)_____

WorkMailingAddress:_____

Since Wisconsin Medicaid payments cannot be made payable to me, I, _____, hereby direct the fiscal agent for Wisconsin Medicaid, EDS, to make checks payable to (clinic or supervisor's name for providers other than mental health) _____ for all claims payments for services performed by me under Wisconsin Medicaid. I understand that this payment arrangement shall continue in effect until the fiscal agent receives a new Declaration of Supervision form from me. When my supervisor, employer or work address changes, I will immediately send this form completed again to the fiscal agent.

_____ _____ _____
Date Signature of Non-Billing Provider Wisconsin Medicaid Provider Number

To be completed by the Supervisor (always required):

Name:_____ Employer IRS #_____ Phone:(_____)_____

Address:_____

I, _____, am supervising the work of _____.
The effective starting date of my supervision was _____. I hereby acknowledge and agree to the above payment arrangement. I understand that if my name is indicated in the above section, Wisconsin Medicaid checks for services provided by the above provider will be payable to me directly and will be reported under the IRS# written here. If I discontinue supervision of the above, I understand that I must send notice to the fiscal agent at the above address.

_____ _____ _____
Date Signature of Supervisor Wisconsin Medicaid Provider Number

To be completed by the Clinic Manager (required for mental health non-billers only):

NOTE: Outpatient mental health/AODA clinics who employ non-billing providers *must* be certified by the Division of Community Services *and* Wisconsin Medicaid. Staff of non-51.42 board clinics providing Wisconsin Medicaid services *must* be individually certified.

On behalf of (Clinic Name) _____, (Wisconsin Medicaid Provider Number) _____, I hereby acknowledge and agree to the above payment arrangement. I understand that Wisconsin Medicaid checks for services provided by the above non-billing provider will be payable to the clinic and reported under this IRS#.

_____ _____ _____
Date Name and Signature of Clinic Manager Employer IRS #

Clinic Address:_____ Phone:(_____)_____

Appendix 15
Paperless Claim Request Form

Wisconsin Medicaid offers many different methods for submitting Medicaid claims electronically. All of this information is available for downloading from the EDS bulletin board system (EDS-EPIX). By downloading, you are able to obtain this information within minutes at your convenience. Please refer to the back of this page for the "Quick Guide to Obtaining Medicaid Electronic Claim Information" to assist you with the downloading process.

☐ **ECS (Electronic Claim Submission):** EDS supplies free software that runs on a stand-alone IBM compatible computer and uses a Hayes compatible modem. Electronic record layouts are also available to create your own data files containing Medicaid claim information.

☐ 3 1/2" diskette ☐ 5 1/4" diskette

☐ **3780 Protocol:** 3780 protocol is an IBM communication protocol that enables mini or mainframe computers to send claim data files to EDS.

☐ **Magnetic Tape:** Providers with the capability to create claim information on tape can submit those tapes to EDS. EDS also provides Remittance Advice information on magnetic tape.

☐ **MicroECS:** MicroECS allows providers to send data files to EDS using most basic telecommunication packages at a line speed up to 9600 bps.

☐ **Reformatter:** The Reformatter is software designed for EDS that enables providers to enjoy the benefits of electronic billing without making costly changes to their existing billing system. Instead of printing claims on paper, claims are printed to a data file on a personal computer and transmitted to EDS. EDS reformats the data into the required electronic record format and brings the claims into the Medicaid processing system.

☐ Please send me additional information on EDS' bulletin board system (EDS-EPIX).

If you are unable to download and would like information on electronic claim submission, please check off the above method(s) you are interested in and complete the following:

Name: _____ Provider Number: _____

Address: _____ Type of Service: _____

_____ Contact Person: _____

_____ Phone Number: _____

Please return to: EDS
6406 Bridge Rd.
Madison, WI 53784-0009
(608)221-4746

EDS-EPIX (V 1.1) Quick Guide to Obtaining Wisconsin Medicaid Electronic Information

This is a quick guide to retrieving and installing the EDS Electronic Claim Submission software using *EDS-EPIX*.

1. If you wish to obtain EDS Software, create a subdirectory on your hard drive for your Electronic Claim Submission software called "EDS." At the DOS command prompt, type:

   C: <Enter>
   CD\ <Enter>
   MD EDS <Enter>

2. Set up your communication software to dial *EDS-EPIX*. You may need to program your software to dial with the following settings:

Phone Number: (608) 221-8824		**Stop Bits:**	1
Baud Rate:	14,400 (maximum)	**Duplex:**	Full
Parity:	None	**Protocol:**	XMODEM (recommended)
Data Bits:	8	**Terminal Emulation:**	ANSI

3. Dial into *EDS-EPIX*. When you go through this initial log-on, we recommend you select Xmodem/CRC as your default protocol.

4. Select option "F" (File Directories) from the main menu and view the "ECS Software and Manuals for New Users" or the "Record Layout and Manual Updates" directory. Choose the name of the file you need to download. If you need help deciding which file you need, go back to the main menu and view Bulletin #2 or 3 for more information. When you have chosen a file, write down the file name (you will need it to download).

5. Select option "D" (Download a File) from the main menu and type the file name you chose in step 4. Next, follow the download instructions in the user manual for your communications software package. This involves telling your communications software package that you wish to "Receive a File," choosing a transfer protocol, and specifying the name and directory path of the file. If you fail to specify the directory path with the file name, the file will be downloaded into the default download directory for your communications software.

6. When you have downloaded your file, select "G" (Goodbye) to end your *EDS-EPIX* session, quit your communication software and return to DOS.

7. Go to the subdirectory you specified in your path and look for your download file. It should be listed when you list the directory.

8. If the download file is in the directory, you will need to decompress the file. At the DOS command prompt, type the name of the download file without the ".EXE" extension. For example: for dental software, at the DOS command prompt, type:

   DENTAL <Enter>

9. This will extract your software and manual(s).

10. The files ending in .DOC are your manuals. This manual is an ASCII DOS text file. To print this document, use the DOS Print command:

    PRINT *FILENAME*.DOC <Enter>

    The document will be printed on the print device you specify.

Appendix 16
Avoiding and Resolving Common Claim Denials

EOB code	Message/Resource/Related Claim Form Element
281	Recipient Medicaid identification number incorrect Medicaid identification card or other eligibility resource Part A, the all-provider handbook, Section I-C Element 1a
29	Recipient's last name does not match number Medicaid identification card or other eligibility resource Part A, the all-provider handbook, Section I-C Element 2
614	Recipient's first name does not match number Medicaid identification card or other eligibility resource Part A, the all-provider handbook, Section I-C Element 2
278	Medicaid files show recipient has other health insurance Part A, the all-provider handbook, Appendix 18 Element 9 (if paid also use element 29)
10	Recipient eligible for Medicare; bill Medicare first Part A, the all-provider handbook, Appendix 17 Medicare-allowed charges ☞Attach Medicare EOMB Medicare-denied charges ☞Element 11 (use M-code and do not attach EOMB)
433	Occupational therapy limited to 35 treatments without prior authorization Part P, Section III Element 23
172	Recipient not eligible for date of service billed Medicaid identification card or other eligibility resource Part A, the all-provider handbook, Section I-C Element 24a
171	Claim/Adjustment received after 12 months from date of service Part A, the all-provider handbook, Section 9-F Element 24a
177	Place of service invalid or not payable Part P, Section IV, of this handbook Element 24b
180	Procedure not payable for type of service or invalid type of service code submitted Part P, Section IV, of this handbook Element 24c
388	Procedure code is incorrect and/or the type of service is not correct for the procedure Part P, Appendix 5 and Section IV, of this handbook Element 24c and/or 24d
183	Provider not authorized to perform procedure code and/or type of service code

Part P, Appendix 5 and Section IV, of this handbook
Element 24k

EOB code	Message/Resource/Related Claim Form Element
175	Performing Provider number is missing/invalid for this procedure Element 24k
424	Billing provider name/number missing, mismatched, or invalid Element 33
100	Claim previously/partially paid on (claim number and R & S date) Part A, the all-provider handbook, Appendix 27 Adjustment Request Form
399	Date of service must fall between the prior authorization grant date and expiration date Part A, the all-provider handbook, Section III-B

Note: HCFA 1500 claim form completion instructions are in Appendix 3 of this handbook.
Request an amendment to authorized prior authorization grant and/or expiration dates to conform to the actual dates of service rendered.

Remittance and Status (R&S) Report with EOB Codes Example

REMITTANCE AND STATUS REPORT

EDS - Fiscal Agent For the Wisconsin Medical Assistance Program
6406 Bridge Road
Madison, WI. 53784
Voice Response 800/947-3544 608/221-4247
Policy/Billing 800/947-9627 608/221-9883
Eligibility 608/221-9254

EDS FEDERAL CORP. WISC.

R/S NUMBER 8451981
PROVIDER NUMBER 051976 REPORT SEQ NUMBER 1 DATE 12/14/97 PAGE

PATIENT NAME/ID NUMBER / SERVICE DATES FROM	TO	UN DS	PERF PROV/ RX NUMBER	MEDICAL RECORD NO / DAYS QTY	T S	PROC/ACCOM/ DRUG CDE/M1 M2	ACCOUNTING NO / CLAIM NUMBER / PROCEDURE/ACCOMODATION/DRUG DESCRIPTION	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
**********													**
*													*
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Appendix 17
Blank HCFA 1500 Claim Form

APPROVED OMB 0938 0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500